Child and Adolescent Health Questionnaire

Amherst Pediatrics
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Please complete this questionnaire to the best of your knowledge. The information concerns your child's and family's health. It will become a part of your child's medical record and will be protected by a strict policy of confidentiality. If you cannot answer a question, please leave it blank. Thank you for your cooperation.

Date ______________ Sex: ☐ Male ☐ Female

Patient's Name ____ Practitioner/Nurse ____________________

Address ____

Day Phone# ____________________ Evening Phone# ________________________ Age ________________________

Household/Family Members

	Name	Birthdate	Occupation	Healthy?	Lives in Household?
Parent					
Parent					
Brother 1.					
Brother 2.					
Sister 1.					
Sister 2.					
Other					

Child's Family History

Check if any blood relatives (parent, brother, sister, or children) have any of the following:

- ○ Do not know my child's family medical history
- ○ Alcohol/Drug Problem ____
- ○ Asthma/Hay Fever ____
- ○ Birth Defects/Mental retardation ____
- ○ Cancer ____
- ○ Diabetes ____
- ○ Heart attack/stroke (before age 55) ____
- ○ High blood pressure ____
- ○ High cholesterol ____
- ○ Mental illness/emotional problems ____
- ○ Physical/Sexual abuse ____
- ○ Seizures (epilepsy) ____
- ○ Tuberculosis ____
- ○ Other (list) ____

LIST THE CAUSE OF DEATH OF CLOSE RELATIVES TO THIS CHILD:

RELATIONSHIP TO CHILD	AGE	CAUSE OF DEATH

TURN OVER

Stress/Emotional Health

■ **In the past year, did you have any major changes or problems with the following:**

- ○ **Job**
- ○ **Personal or family relationships**
- ○ **Personal illness or injury**
- ○ **Major illness or death of a close family member or friend**
- ○ **Finances**
- ○ **Moved/relocated**
- ○ **Other**
- ☐ **None**

LIST ALL CHILD'S HOSPITALIZATIONS, SERIOUS ILLNESSESS, OPERATIONS, AND SERIOUS INJURIES:

DATE ______ AGE ______ REASON ______

______

______

______

■ Any problems during the pregnancy or birth?.................. ○ **Yes** ☐ **No**

Please give details of any birth problems______

______

Child's Health Summary

■ Check all that apply to child now, or in the past.

- ○ Alcohol/drug problem
- ○ Allergy: What______
- ○ Bedwetting
- ○ Behavior problems
- ○ Repeated ear infections
- ○ Emotional problems
- ○ Problem making friends
- ○ Heart murmur/heart problem
- ○ School/learning problems
- ○ Sexually transmitted disease
- ○ Around smokers
- ○ Around alcohol/drug abusers
- ○ Other: (list)______
- ☐ Check here if **none** of the above

■ In general, would you say that your child's health is:

☐ Excellent ☐ Very Good ☐ Good ○ Fair ○ Poor

■ Do you have any concerns about your child's growth and development? ○ Yes ☐ No

If yes, describe______

■ **CURRENT MEDICATIONS:**

List all medications-include fluoride, vitamins, inhaler, and over-the-counter medications.

☐ Check here if NONE.

______

______

■ What does your child do in his/her spare time? ______

■ How much TV/computer time each day? ______

■ For school age children: How many days of school has your child missed in the past six months?______

■ When did your child last have a complete check-up/physical exam? Age______

Physician or clinic name______

IMMUNIZATION HISTORY: Please bring records with you or request from your child's last doctor/practioner.

■ Do you think your child is up-to-date on immunizations? ☐ Yes ○ No ○ Unsure

We look forward to working with your and your child.

■ **END**